WESTERN RESERVE HOSPITAL
Proudly Physician Owned
Partnering with University Hospitals

WRH PHYSICIANS, INC.

Patient Information	Please Make Changes Here
Primary Care Physician	_____
Patient Name	_____
Patient Address 1	_____
Patient Address 2	_____
City, State Zip	_____
Phone #	_____
Marital Status	_____
Date of Birth Sex	_____
SSN #	_____
E-Mail Address	_____
Primary Pharmacy Name	_____
Primary Pharmacy Phone #	_____
Race	_____
Ethnicity	_____
Emergency Contact	_____
Emergency Phone #	_____
Patient Employer	_____
Employer Address	_____
Primary Insurance	_____
Group #	_____
ID #	_____
Policy Holder Name	_____
DOB	_____
Secondary Insurance	_____
Group #	_____
ID #	_____
Guarantor Name	_____
Guarantor Address	_____
City, State Zip	_____

All professional services rendered are charged to the patient, necessary forms will be completed to help expedite insurance carrier payments. If you are covered by a plan with a restrictive network, it is your responsibility as the insured/patient to seek professional care with a participating provider within your plan. The patient (or guardian) is responsible for all fees, regardless of insurance coverage

I hereby give the physicians of WRHPI permission to treat me or my dependent(s), and I authorize WRHPI to furnish any medical information necessary for insurance claim submission and/or payment. I understand that I am responsible for any remaining fees not covered by insurance.

I further understand that some or all of the services rendered may be deemed “non-covered” by my insurance carrier and that I will be billed for such services.

I authorize payment of medical benefits to the physicians of WRHPI for services described herein. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees and services rendered.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

DISCLOSURE OF PERSONAL HEALTH INFORMATION

Ohio Public Health Reporting

To keep track of Patients' adult and childhood immunizations and health information, your Western Reserve Hospital Physicians Inc. Providers use the Ohio Department of Health secure, online system, called Impact Statewide Immunization Information System (ImpactSIIS). In addition to immunizations, body mass index, vision, lead, tuberculosis and hearing measures are reported to ImpactSIIS. The primary benefit of ImpactSIIS is that State of Ohio authorized users like schools, local health departments, immunization providers, and Women Infants and Children (WIC) program staff, may access your immunization and health information, even if you move. Please note that not all authorized entities use ImpactSIIS. If you have additional questions about ImpactSIIS, please call the Ohio Department of Health at 1-866349-0002 or (614) 466-4643 or send an email message to impact@odh.ohio.gov. If you do not want your immunization and health information included in ImpactSIIS, ask your Provider or the Ohio Department of Health for the ImpactSIIS Removal Request form.

Health Information exchange (HIE)

We participate in one or more Health Information Exchange (HIE). As your healthcare provider, we may appropriately access your health information electronically, as well as securely share your health information with other health information exchange participants For example, if you see a WRH Physicians Inc. provider and then visit a hospital that participates in the HIE, that hospital would be able to access your WRH Physicians Inc. medical chart information. This is a voluntary agreement. You may opt-out at any time by notifying our office.

Personal Health Information Release / Emergency Contacts:

Name: _____ Name: _____

Relationship: _____ HomeRelationship: _____ Home

Phone #: _____ Phone #: _____

Cell Phone #: _____ Cell Phone #: _____

Is this person able to receive your Personal Health Information? Yes No

Is this person able to receive your Personal Health Information? Yes No

What is your preferred contact number for appointment reminders and messages?

Preferred Phone#: _____

What is your preferred time of day for appointment reminders and messages? ☐ Morning

Afternoon ☐ Evening

If Cell is preferred, is text allowed? ☐ Yes ☐ No

Would you like to be web enabled for our patient portal? ☐ Yes ☐ No

If yes please provide your email address _____

Preferred Pharmacy Name: _____

Preferred Pharmacy City: _____

Preferred Pharmacy Phone Number: _____

☐ Retail Pharmacy ☐ Mail Order Pharmacy

On occasion, we may need to call you and leave information regarding results of any treatments or tests that you have had. May we leave this information on your voicemail? ☐ Yes ☐ No If yes please circle preference:

Home Phone or Cell Phone

Brief or Extended

I, _____ do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies, and Procedures.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

WRH Physicians Inc. is part of the Western Reserve Health System (WRHS). As part of our involvement with WRHS, we have implemented an electronic medical record in order to improve the efficiency in our offices and provide the highest quality healthcare services to our patients.

As part of that process, we will be able to check the medication history of all of our patients via a secure, electronic system; and we are able to seamlessly share patients' clinical information with other providers that are or may be involved with our patients' care. In addition, we continue to follow the regulations associated with the Health Insurance Portability and Accountability Act (HIPAA) and a notice of our privacy practices is available to you upon request.

We hope you recognize the importance of the steps we are taking in order to provide high quality, efficient, healthcare services. As always, our patients are our number one priority.

Sincerely,

The Physicians and Staff of WRH Physicians Inc.

Please sign below indicating your receipt of this notification:

Print Name: _____

Signed: _____ Date: _____

Parent or Guardian Signature (if applicable):

_____ Date:_____

WRH Physicians, Inc.
Financial policies

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a summary of our Financial Policies which we require you to read and sign prior to initial treatment. We welcome the opportunity to discuss any aspect of our financial policies with our patients. Please feel free to contact our billing office at 330-923-5899 Monday thru Thursday 7:00 a.m. to 6:00 p.m; or Friday 7:00 a.m. to 4:00 p.m.

INSURANCE CARD

It is very important that we receive the correct insurance information. Please present all current insurance card(s) at the time of service. Due to the many changes that occur in insurance coverage, you will be asked to present this card(s) at each visit. We will make every effort to bill your insurance company based on accurate, current information presented to us at the time of service.

CO-PAYMENT

Our contracts with insurance companies require that we collect the entire co-payment at the time of service. You will be assessed a $20.00 administrative charge for not paying your co-pay at the time of service.

INSURANCE PARTICIPATION

WRH Physicians, Inc. makes every effort to participate with insurance plans for the convenience of our patients; however, you are responsible for knowing your insurance coverage. Please verify your physician's participation, referral and pre-cert requirements with your insurance company prior to your appointment. WRH Physicians, Inc. assumes no liability for non-coverage due to insurance participation and/or plan design. You will be responsible for any balance that results as out-of-network benefits or non-participating provider. We do not accept UCR from non-participating insurance companies.

APPOINTMENT CANCELLATION

There will be a $25.00 fee for all appointments that are not attended and not cancelled at least 24 hours prior to scheduled time. This charge is not covered by insurance companies. After three (3) no-show or failed appointments, you may be dismissed from the practice.

PRESCRIPTION REFILLS

Please remember to obtain your prescription refills during your office visit.

INSURANCE PAYMENT/PATIENT RESPONSIBILITY

After receiving payment from your insurance company, we will send you a statement for any additional patient responsibility. All balances billed are due within 30 days of the first statement. Unpaid balances greater than 90 days are subject to our collections process. An interest surcharge will be applied to any unpaid balances.

SELF-PAY DISCOUNTS

We offer a self-pay discount to patients that do not have any type of insurance. This discount is only available if charges are paid in full at the time of service. Our physicians will code the service to the level of specification appropriate for the service rendered, which has a corresponding self-pay charge.

All services provided for an MVA or Personal Injury claim will be billed to your medical insurance as long as we are "in-network" with your insurance carrier. You are responsible for all copayments, coinsurance, deductibles, and non-covered services. We do not bill "out-of network" insurance carriers for conditions related to MVA or Personal Injury claims. We do not bill auto, home or other non-medical insurance. Patients presenting with conditions covered by these types of policies will be considered self-pay and payment in full is required at the time of service. We do not offer self-pay discounts for MVA or Personal Injury claims.

NON-COVERED SERVICES

All services deemed non-covered services by your insurance company are the responsibility of the patient or the patient's guarantor.

I have read the Financial Policy. I understand and agree to this Financial Policy. I verify the billing information provided is accurate and authorize release of any medical information necessary to process claims. I request payments be sent directly to the physician of the services provided when the physician accepts assignment of my insurance benefits.

I further understand and agree that my failure to follow this Financial Policy may result in WRH Physicians, Inc. terminating my patient-physician relationship.

_____

Patients Signature (or Parent/Guardian Signature as applicable)

Date _____Print Signed Name_____